Society Proceedings

BOSTON SOCIETY OF PSYCHIATRY AND NEUROLOGY.

January 21, 1904.

The President, Dr. G. L. Watron, in the chair.

Brain Tumor with Astereognosis.—Dr. E. W. Taylor reported this case.

The patient, referred by Dr. Vivian Daniel, was a man of twenty-nine, married, who had been ailing for seven months, dating from an attack of influenza. He was at that time ill in bed and made a poor recovery. He had persistent headache, chiefly frontal, at first unassociated with nausea. Four weeks before he was examined, on April 18, 1903, he gave up work on account of general weakness. Three weeks previous to his first visit numbness and weakness of the right hand developed. At the time of examination he was somewhat unsteady in walking; his eyesight was not impaired; his appetite and sleep were sufficiently good. He had lost some thirty pounds in weight, twelve in the last three weeks. The right pupil was slightly larger than the left; there was no defect in light reaction, or on accommodation. There was a suspicion merely of optic neuritis. The cranial nerves showed no paralysis; the speech was slightly thick, but there was no mental impairment; the right hand and arm were extremely weak without marked alteration in the reflexes. The sensibility of the hand was normal to painful stimuli and to contact, but showed a complete astereognosis. No object placed in the hand was rightly interpreted. The pulse was 140; respiration was rapid; knee-jerks were lively; there was no Babinski. A few days later nausea and vomiting developed, together with spasms of the right hand and arm and increased mental irritability.

Electrical examination showed nothing abnormal. Treatment with iodide was unavailing. The temperature was at this time, and had been for many weeks, elevated several degrees. A later examination showed a marked increase of the symptoms given above, and in view of the fact that physical examination was otherwise negative, operation was decided on in spite of the elevation of temperature because of the evident localization of the new growth, and also because the patient was rapidly failing.

Operation was done May 1st, by Dr. F. B. Lund. Several nodules of a hard tumor were easily extracted from the arm area, mainly anterior to the fissure of Rolando. Temperature at the time of operation was 103.5°. The patient made a good recovery from the operation; was relieved completely of his headaches; was without discomfort, excepting for the presence of a right hemiplegia. He died May 28th, slight improvement in motility having taken place during the interval. Autopsy, May 28th, showed an extremely active miliary tuberculosis, with a primary focus in the prostate. The brain, apart from the tumor, which on microscopic examination proved to be tuberculous, showed only a very slight tubercular basal meningitis. Other organs were thickly studded with miliary tubercles.

The interest of the case centers in the following points: The failure to determine the presence of tuberculosis, although it was suspected; the possibility of successful operation in the presence of considerable elevation of temperature; the localization of the tumor anterior to the fissure of Rolando, but associated with a definite astereognosis coinciding with the view of Walton and Paul; and finally the significance of the symptoms as again pointing to the sensory motor character of the Rolandic cortex, as pointed out by Dana and others.

Dr. Lund described the operation and spoke of the resulting relief of headache.

Temporary Paralysis.—Dr. Knapp showed a man, aged thirty-nine (39), who five years before had suddenly lost power in the left arm for about ten minutes. Since that time he has had similar attacks at varying intervals, once in five or six weeks, even two or three in an hour. When the attacks occur frequently he does not fully regain use of the arm in the interval. With the attack there is a sensation of numbness, which extends over the shoulder and chest, and sometimes over the face. Once it extended to the leg and the leg muscles were slightly affected. In the attack there is no convulsive movement, no loss of consciousness, no flushing of the face, no change of temperature and no change in the pupils. There has been no headache, vertigo, nausea, vomiting, somnolence, mental disturbance or optic neuritis. The physical examination was absolutely negative, except that after an attack there was diminished sensibility to pain, touch, motion and position in the hand. The attacks were somewhat controlled by bromide. The long continuance of the attacks without other symptoms rendered a diagnosis of general paralysis improbable. Binswanger has cited cases of epilepsy in which the attack was attended with paralysis instead of convulsion, and that diagnosis seemed probable in this case.

Dr. Webber recalled the case of a man who without loss of consciousness had sudden loss of power in one arm lasting only half a minute, so that he would drop whatever the hand held, but was immediately able to use the member perfectly. The attacks were deemed epileptic.

Resection of the Spinal Accessory Nerve.—Dr. Paul showed a patient 2½ years after resection of the spinal accessory nerve by Dr. Richardson, and subsequent prolonged rest for spasmodic torticollis. The muscles paralyzed by the operation have regained their tone and are under voluntary control. There is only rarely spasmodic twitching of the sternocleido, or trapezius. The result seems satisfactory.

Dr. Putnam thought that when spasmodic torticollis could be relieved without resort to operation it was preferable.

Dr. Folsom reported a case relieved by non-operative treatment.

Dr. Baldwin referred to the lasting immunity from spasm in a severe case operated upon by Dr. Richardson several years ago.

Dr. Knapp said that he and Dr. Putnam had recently seen a mare who apparently had spasmodic torticollis. The mare was out of a thoroughbred dam by a French bred coach horse, and had won various prizes. She first came in season at the age of three, and at times after that, when in season, she would try to bite her tail. She was not nervous, although she was obstinate and would behave badly if not harnessed to her liking. She showed none of the equine stigmata of degeneracy. About a year ago, possibly after exposure, she began to turn her head toward the off side, the spasm recurring several times a day and lasting two or three minutes. She has had as many as nineteen of these spasms in an hour. They are usually worse when she is in season. The spasm can be felt by a person on her back to involve the muscles of the flank and rump, but it does not cause any change in her gait, either the walk, trot or canter. She does move her forward feet a trifle in the spasm to preserve her balance. There is no history of injury, no tender spot and no spot which seems by pressure to influence the spasm. Massage, electricity, ounce doses of Fowler's solution, and large doses of bromide and chloral had no effect. Absolute rest in a box stall had apparently made her worse. Breeding and the freedom of a paddock had been suggested. The spasm seemed to involve chiefly the levator humeri and the sterno-maxillary muscles, the analogues of the levator anguli scapulæ and the sterno-mastoid. The circular nerve of Willis, analogous to the spinal accessory, supplies these muscles in part, and in one place is quite superficial. The nerve is often divided at this point to prevent cribbing, and this operation is now proposed for this condition.

The case is apparently unique. None of the veterinary surgeons here or in New York and no stable men have ever seen anything like it. Dexler in his "Nervenkrankheiten des Pferdes" describes a facial tic in the horse and other forms of tic, but nothing like this. Rudler and Chomel (*Revue Neurologique*, XI, 541, 15 June, 1903,) describes various forms of tic in the horse, notably the "tic de l'ours" or "weaving," but no reference has been found to any condition such as this mare presents, which closely resembles spasmodic torticollis as observed in man.

Dr. G. A. Blumer was elected President of the Society for the ensuing year. He called on Dr. Dana, of New York, for the paper of the evening, on:

"The Partial Passing of Neurasthenia.—Dr. Dana, the writer, described the five great groups of the major psychoses or insanities, excluding the insanities from accidental and organic causes. These different groups each represent different and more or less deeper variations from the line of normal mentality, and depend upon a different degree of constitutional weakness. These great groups are the primary and precocious dementias, paranoia, the mania-melancholia psychoses, or manic-depressive insanity, including the chronic melancholia of involution, phrenasthenia, or the degenerative or neurasthenic insanities, and the exhaustion and toxic psychoses. The author's contention is that more than 50 per cent. of cases, usually called neurasthenia, can be assigned to one or the other of these groups. They are either cases in the forming stage, or they are mild and abortive attacks. Neurasthenia, so called, is often, he thinks, a *form fruste,* or a shadowy imitation, or a prodrome of the great psychoses. Thus, half of all neurasthenias would properly be called neuro-psychoses, or, if the form is preferred, psycho-neuroses. The larger part of these psycho-neuroses are probably related to phrenasthenia, which group includes the hysterias as well as the so-called neurasthenias, with doubts, fears, obsessions, impressions, and so on. A very large number of neurasthenias really belong to the manic-depressive type, and occur in the form of mild attacks of recurrent melancholia, in which often there is not very much melancholia, but only a general depression, with retardation of thought and psychæsthenia. Many of the cases of neurasthenia also found at and after the age of 45, belong with the chronic melancholia of involution, and are really only mild attacks of this psychosis; they are the forms often classed as "depressive neurasthenia" or "anxiety neurosis," and so on. True neurasthenia rarely begins before 25, and the writer called attention to the importance of carefully studying the cases that are supposed to be neurasthenic, occurring in the early period of life. Some of these are the pseudo-neurasthenia preceding dementia præcox, some of them are forms of phrenasthenia or melancholia. The writer dwelt upon the particular importance of studying the mental symptoms in neurasthenics, in order to detect the relationship of their condi-

tion to one or the other group of the major psychoses. The real neurasthenias, he considers, to be usually essentially local diseases, due to some unusual irritability or disturbance of a nervous mechanism. The terms, "congenital neurasthenia" and "hypochondriasis," he thought, could be dispensed with. He would also put the compulsions and impulsions, which are classed as separate insanities, under the general group of the phrenasthenias. The writer did not deny the importance of bodily troubles as a cause of the minor psychoses, but thought that treatment can be made more effective and prognosis more certain, by the knowledge of the exact relationships of the so-called neurasthenia to the groups of the major insanities.

The President, in calling for the discussion of the paper, commented upon the essential unity of nervous and mental diseases. The latter, he said, were merely nervous diseases with greater prominence of the mental symptoms. He welcomed the commoner use of the term "phrenasthenia," which the French had found useful, and approved the essayist's attempt to popularize it as one that described more accurately, in the majority of instances, the symptom complex which neurologists, as a sweeter morsel for the invalid's tongue, had described under the all-inclusive "neurasthenia," whose partial passing the distinguished visitor from New York had come to Boston to proclaim. He animadverted banteringly, and with an attempt at defence, as himself a recent comer to New England, on the pronunciation of the word "neurasthenia" as current in these parts and nowhere else, the adoption of which by the essayist would entitle him at once, despite his modest protest, to recognition in New England as to the manner born.

Dr. Putnam agreed in general with the reader, and emphasized the mental element in neurasthenia. Still, Dr. Dana's classification is not quite satisfactory, for the psychoses are merely variations of the normal state, which is itself not stable or uniform. While admitting, then, the relationship between neurasthenia and mental disease, he would regard these variations only as lines of cleavage. He was fully in accord with Dr. Dana regarding the melancholia of involution. He objected to laying too great stress on the mental aspect of neurasthenia, and deplored a change which should render all neurasthenics liable to be deemed abortive mental cases.

Dr. Walton agreed with the reader regarding the limitation of the diagnosis neurasthenia. In the Neurological Department of the Mass. Gen. Hospital during October, November and December, 1896, this diagnosis was made 43 times, whereas it had been made during the same months of the past year only eleven times, which would have corresponded to about 16 times, if the number of cases had been the same. Most of the cases classed formerly as neurasthenia were now transferred to the "psychoneuroses." He did not think they had often mistaken dementia præcox, or paranoia, for neurasthenia.

Dr. Knapp believed there were many cases of true neurasthenia or inevitable weakness—a condition of pathological fatigue. In uncomplicated cases the mental symptoms are not prominent. Study of a number of cases diagnosticated as neurasthenia showed definite mental symptoms in only a small percentage. A distinction must be made, however, between simple mental depression and true melancholy states. Every sick person is apt to be depressed. This is physiological and should not be classed as melancholia. In only a comparatively small proportion of neurasthenics are there insistent ideas, morbid doubts, morbid fears and other indications of the ideo-obsessive tendency. When a patient becomes weak, however, he begins to distrust his own powers and in this way, especially among the "deviates" and those of an unstable mental organization, morbid doubts and fears may develop. In other cases obsessions may arise in a person who is not neurasthenic, and the struggle against them may so exhaust the patient as to give rise to neurasthenia. We can usually distinguish, however, which is primary. Obsessions sometimes develop into actual delusions, akin to the delusions of paranoiac states;—in fact, folie du doute is sometimes spoken of as abortive pananoia. His experience agrees with that of Dr. Walton that as a rule we do not find any tendency to paranoia, or dementia, among neurasthenics.

Dr. Courtney spoke of pathologic fatigue supposed to underlie the neurasthenic state. One is too prone to believe that because over-fatigued honey bees and humming-birds show changes in the nerve cells, analagous changes take place in the human species. Such assumption is unwarranted by clinical experience. In a neurasthenic who can barely crawl from home, yet who walks homeward with buoyant step, the conditions are psychical rather than physical. Whether called phrenasthenia or psychæsthenia, it is to a limited extent a mental degradation, a pathologic state of nolition, and the simulacrum of various forms of insanity.

Dr. McDonald regarded true melancholia and true paranoia as rare, the former falling generally under manic-depressive, the latter under dementia præcox. He coincided with the reader in limiting the use of neurasthenia.

The term congenital neurasthenia, though scarcely permissible for the characterization of a special group, has been of some use in differentiating patients with congenital pathological tendencies.

Dr. Dana said in concluding that cases of neurasthenia allied to or leading up to dementia præcox, were not very dangerous, but their serious character made it very important to recognize them. They were in persons under 25.

There were relatively few cases of abortive types of paranoia passing around as neurasthenias; yet they did exist in the early depressed and moody stage.

The largest number of cases miscalled neurasthenia came under the head of phrenasthenia. The group in its well-marked forms was easily recognized as hysteria, doubting mania, morbid fears, obsessions, and so forth. It was the imperfectly developed forms that were unrecognized and which passed as "nervous exhaustion."

A great many cases of mild recurrent melancholia or manic-depressive insanity were classed as neurasthenia. The speaker thought this would not occur if a more serious study of the mental state were made.

He was inclined to favor the view of Dr. McDonald that paranoia should be classed with paranoid dementia.

He would still recognize some cases as real neurasthenia; the others were "psychoneuroses," and then could be further distributed mostly as phrenasthenia or depressive psychoneuroses.